

## SECTION H – PROVIDER MANAGEMENT

**H.1 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.**

### Overview

Louisiana Healthcare Connections (LHCC) utilizes a multi-faceted approach to ensure providers are available and accessible within an appropriate timeframe to meet our members' medical needs. This approach includes collaboration across multiple departments who support providers to ensure provider adherence to the appointment access and availability standards and consistency in the information imparted to providers and staff.

Our provider accessibility monitoring activities extend not only to our immediate network of participating providers (PCPs and specialists), but also to our subcontracted vendors and providers that include, but are not limited to, our non-emergency medical transportation, vision care, and radiology services vendors.

LHCC understands and will comply with all standards and requirements in Sections 6.14.7 Family Planning Accessibility, Section 7.0 General Network Requirements including Section 7.2 Appointment Availability Access Standards, Section 7.5 Appointment Availability Monitoring, Section 7.8.3.5 Minimum Availability of Specialists, and Appendix SS – Provider Network – Appointment Availability Standards, including wait times and all other relevant standards and requirements.

### Appointment Availability Standards

LHCC follows appointment availability and wait standards in accordance with Section 7.2, Section 7.8.3.5 and Appendix SS, which were established by DHH as minimum requirements to sufficiently meet our members' needs. We contractually require our providers to comply with these standards, and we measure compliance with the following monitoring tools:

Appointment Type	Appointment Standard	Monitoring Tool
Emergencies and Urgent Care		
Emergency Care	24 hours, 7 days/week	Provider Self-Report Surveys Weekly Provider Visits Provider Complaint/Member Grievance Analysis CAHPS Survey (Systemic Issues)
Urgent Non-emergency Care	24 hours, 7 days/week	
Primary Care		
Non-Urgent Sick	72 hours	Provider Self-Report Surveys Weekly Provider Visits Provider Complaint/Member Grievance Analysis CAHPS Survey (Systemic Issues)
Non-Urgent Routine	6 weeks	
Urgent Care, including walk-in patients	Within 24 hours	Provider Self-Report Surveys Weekly Provider Visits Provider Complaint/Member Grievance Analysis CAHPS Survey (Systemic Issues)
Emergent or emergency visits	Immediately upon presentation	Provider Self-Report Surveys Weekly Provider Visits Provider Complaint/Member Grievance Analysis CAHPS Survey (Systemic Issues)
After Hours Coverage by phone	Answer by live person or call-back from a designated medical practitioner within 30 minutes	After Hours Coverage Survey Provider Complaint/Member Grievance Analysis

Appointment Type	Appointment Standard	Monitoring Tool
Family Planning Services	Available within 1 week	Provider Self-Report Surveys Weekly Provider Visits
Prenatal Visits		
1st Trimester	14 days	Provider Self-Report Surveys Weekly Provider Visits CAHPS Survey (Systemic Issues) Provider Complaint/Member Grievance Analysis
2nd Trimester	7 days	
3rd Trimester	3 days	
High risk pregnancy, any trimester	3 days	
Specialty Care		
Specialist Appointment	1 month, or as clinically indicated	Provider Self-Report Surveys Weekly Provider Visits Provider Complaint/Member Grievance Analysis Mystery Shopper Audit Calls EQRO Survey
Waiting Room Time		
Scheduled Appointments	< 45 minutes	Provider Self-Report Surveys Weekly Provider Visits Provider Complaint/Member Grievance Analysis
Accepting New Patients		
The practitioner office is open to new patients	Provider is listed in directory and/or registry file as open	Provider Self-Report Surveys Weekly Provider Visits EQRO Survey Mystery Shopper Audit Calls Provider Complaint/Member Grievance Analysis
Lab and X-Ray Services		
Regular Appointments	Not to exceed 3 weeks	Provider Self-Report Surveys Provider Visits Provider Complaint/Member Grievance Analysis
Urgent Care	48 hours, or as clinically indicated	

Consistent with Section 7.2.1.11, we also require providers to see (if possible) or schedule an appointment for walk-in patients with non-urgent care needs in a manner that is consistent with the providers' written scheduling procedures. In accordance with Section 7.2.1.10, when providers anticipate a wait-time longer than 90 minutes for an LHCC member, we will require providers to offer a new appointment.

### Provider Communication and Education

LHCC's overarching communication objective is to positively reinforce provider behaviors that improve customer satisfaction and access to care. For Medicaid members, the ability to make appointments with their providers without obstacles is a significant contributor to the satisfaction they experience with their providers and LHCC. Consequently, provider compliance with the contract terms related to timely appointments and wait times serves as an integral success factor for LHCC in supporting member satisfaction and care coordination.

**Communication and Training Methods. Initial Provider Recruitment.** Our process for ensuring compliance with appointment and wait time standards begins by communicating and reinforcing minimum availability standards during our initial provider recruitment process. We contractually require all contracted providers to adhere to all requirements set forth in the RFP, the Medicaid MCO Contract, and Medicaid Policy and Procedure Guide. Specific appointment availability standards are incorporated

within our LHC PRVR 04 Provider Appointment Accessibility Standards Policy and our Provider Manual as required in RFP Section 7.5.1.1 and outlined above.

***Credentialing and Ongoing Validation.*** LHCC requires all providers to specify their hours of operation on their credentialing application and during the recredentialing process (which occurs every 3 years). This enables us to identify providers who offer evening or weekend office hours. Our external PR Specialists also collect this info on the Provider Visit Record when they are onsite with providers. Any updates identified from either of these efforts are input into and tracked in our Provider Relationship Management (PRM) system by Provider Relations staff.

Expanding on the latest in Customer Relationship Management (CRM) technology, PRM houses the entire lifecycle of our provider relationships including provider prospecting, recruiting and application processing; credentialing and contracting (with supporting fee schedules and/or other reimbursement arrangements if applicable); continuous provider data management (e.g. demographics; identifiers such as NPI, TIN and DHH Medicaid IDs; affiliations; and specialty codes); provider visit records; and ongoing provider network design and analysis support (through geo-mapping technology).

***Initial Provider Orientation.*** A Provider Relations (PR) Specialist conducts an initial provider orientation with each new provider upon joining LHCC's network and within the first 30 days of participation. During the orientation, the PR Specialist gives providers a copy of our Provider Manual and reviews key topics, such as:

- The provider's contractual obligations related to LHCC's Appointment Availability and Access Standards, and any barriers the provider may have adhering to the standards
- Our comprehensive, written policies and procedures included in our Provider Manual and on our website related to ensuring that our members have access to screening, diagnosis and referral, and appropriate treatment
- LHCC's Quality Assessment and Performance Improvement Committee (QAPI Committee) accessibility oversight activities related to:
  - Provider appointment availability
  - Provider and Health Plan after-hours telephone accessibility
  - Member satisfaction
  - Provider satisfaction
  - Member Grievance System
  - Provider complaint system
- The provider's ability to provide direct contact with a clinical staff person through a toll-free number at all times, as required in Section 7.2.1.12
- The 24/7 nurse advice services available through NurseWise, LHCC's nurse line affiliate
- The breadth of resources available to providers through our website and secure Portal, such as our Practice Improvement Resource Center. See our response to Question H.5 for more details.

***Ongoing Provider Training.*** Ongoing training occurs during routine face-to-face sessions at provider offices; regional workshops; through our Provider Newsletter, Provider Blast Fax, and emails; online tools via the website and secure Portal. Initial and ongoing training topics related to appointment availability and wait times include, but are not limited to:

- Support available from LHCC including calling members to remind them of appointments
- How LHCC monitors compliance with access standards
- Incentives LHCC offers for expanding access, as appropriate

- Review of appointment scheduling timeframes and office wait time standards to which they are bound contractually.

**Provider Coaching.** We encourage providers to notify us right away of changes to their hours of operation. Provider complaints (e.g. a PCP experiencing difficulty getting a patient seen by a specialist) or member Grievances related to appointment availability standards received by internal departments, such as our Call Center, Case Management or Grievance and Appeals Departments are routed to our Network Team. They send the Provider a complaint acknowledgment letter and then our PR Specialists research the complaints or Grievances and coordinate resolution of the issue. Upon resolution, our Network Team sends the provider a letter identifying the issue and resolution, along with the estimated completion date, and schedules a personal provider visit for coaching as appropriate. During these visits, our PR Specialists remind providers of the appointment availability and access standards and discuss ways to solve any barriers or challenges the office is having providing timely appointments for LHCC members. Our PRM and SharePoint systems track, record, monitor, and trend all visit activities and discussions.

### Monitoring and Ensuring Adherence

LHCC monitors adherence to appointment availability and wait time standards through multiple vehicles including, but not limited to, analysis of complaint data, provider visit information, surveys and audit results. We formally monitor compliance with these standards on a monthly basis and use the results to ensure adequate appointment availability, and to reduce unnecessary emergency room utilization. LHCC makes every effort to assist providers in meeting minimum accessibility standards, including peer-to-peer coaching as appropriate.

**Analysis of Provider Complaints and Member Grievances.** LHCC understands that access challenges not only affect our members, they also affect referring providers who coordinate care for members. In order to monitor adherence, we also measure compliance with appointment availability standards through our ongoing analysis of provider complaints and member grievance data specific to individual providers and the network as a whole.

Our Call Center and/or Provider Relations staff address all appointment scheduling and wait time complaints immediately. Similar to our response to noncompliance identified in onsite audits, we work with those providers for whom an accessibility complaint or Grievance has been filed to reinforce expectations and contractual requirements regarding appointments and wait times. We also may initiate Corrective Action Plans (CAPs).

As part of our Provider Network Compliance Review, our PR Specialists and Quality Improvement (QI) staff work together to monitor accessibility-related activities among providers and review member and provider inquiries, provider complaints, and member Grievances in order to identify accessibility trends associated with specific providers. If we identify a trend of three occurrences with a specific provider, a local PR Specialist conducts a provider visit and/or a mystery shopper compliance audit as described below. LHCC also monitors complaints to ensure that services are provided to members without discrimination, including hours of operation.

**Provider Visits.** LHCC's local PR Specialists visit rotating providers on a weekly basis and while onsite, assess adherence with appointment accessibility and wait time standards. As part of the visit, they ask practice staff to show them appointment scheduling policies and assess the waiting room and patient flow. If they identify a concern during the visit, our PR Specialists provide scheduling recommendations and coaching to help the practice address identified issues. PR Specialists document results of the visit in LHCC's Provider Visit Record, and provider office staff sign off on the Record to help ensure both parties agree with the information provided and/or needed.

**“Mystery Shopper” Audit Calls.** On a weekly basis, our PR Specialists call provider offices to verify appointment availability, hours of operation, and 24/7 availability of a contracted provider. These calls provide real time monitoring of appointment access for PCPs and high-volume OB/GYNs and specialists. During a Mystery Shopper audit, PR staff call a provider’s office during normal business hours and after hours, posing as a fictitious LHCC member. If they place the call during business hours, they request the next available appointment. Once the office staff provide an appointment date and time, the surveyor identifies himself or herself, the purpose of the call, and provides the survey results. If the provider’s office offers an appointment within LHCC and DHH standards for the type of appointment, the surveyor credits all providers in the office with meeting the standard. If not, the surveyor immediately reviews the standards with the office staff and requires that CAPs be implemented.

Our Quality Improvement (QI) Department tracks the results of these monitoring activities and uses the results to identify providers who may need targeted education and/or a CAP to bring them into compliance with LHCC’s appointment accessibility standards. PR and QI staff maintain ongoing communication throughout this process. PR then outreaches to providers and visits practices needing additional education to ensure future compliance.

Provider Relations staff communicate assessment results to individual/group practitioners (via follow up letter after the audit is conducted), to LHCC’s senior management team, and to the QI Department for reporting. As an enhancement to this process, our staff will outreach to all providers who initially fail the surveys and a re-audit will be performed within six months. This process is subject to change based on the scope of the McGahee engagement described below. Such changes could include transitioning appointment availability audits to McGahee.

**Mystery Shopper Vendor Engagement.** Our Mystery Shopper Audit Call process, described above, includes after hours coverage surveys. Beginning October 1, 2014, we will transition the Mystery Shopper after hours audit calls to McGahee & Associates (McGahee). Founded in 2009, McGahee provides after hours and appointment accessibility surveys and reporting of results. Other Bayou Health Plans currently contract with McGahee to perform their appointment availability and after hours audits. McGahee’s established relationships with the incumbent MCOs will minimize the amount of duplicate survey and audit calls providers receive because the call results will support any MCO McGahee is contracted with for these services. This also will allow our PR Specialists to spend more time on targeted provider coaching and education needed based on audit results.

McGahee will conduct after-hours access surveys of LHCC providers on an annual basis and audit results will be distributed to our QI and PR departments for review and targeted education, coaching, and/or CAPs as necessary.

**Provider Self-Report Surveys.** In addition to the Mystery Shopper Audit Calls described above, LHCC requests self-reported appointment availability information via an annual provider survey. Upon receipt of the completed survey, and on a weekly basis, LHCC PR Specialists conduct phone surveys to the providers’ appointment scheduler to follow up with providers/staff and validate the results. We adopted the Provider Survey Tool from our parent company, Centene Corporation (Centene), which has used the tool since 2007 for the Medicaid managed care contracts it manages in other states. We communicate overall results to providers in a quarterly newsletter, along with reminders of our appointment availability standards. In addition, PR Specialists continue to educate practitioners regarding appointment availability standards during routine onsite visits.

Survey results for the period January 2014 to August 2014 demonstrate a 93% compliance rate with appointment availability standards across the network, and indicate a positive trend in appointment availability across all appointment categories.

**CAHPS Member Satisfaction Surveys.** LHCC selected The Myers Group (TMG), a National Committee for Quality Assurance (NCQA) certified HEDIS® Survey Vendor, to conduct its 2013 CAHPS® 5.0 Medicaid Adult Member Satisfaction Survey, and Medicaid Child Member Satisfaction Survey (with CCC Measurement Set).

Survey questions applicable to assessing member satisfaction with timeliness of access to health care services include a measure of the percentage of members who reported they “always” or “usually” got *regular or routine care* as soon as they requested it; and the percentage of members who reported they “always” or “usually” got *urgent* appointments as soon as they requested them. Analysis of these survey results enables LHCC to identify systemic trends that indicate the need to implement targeted improvement initiatives that will impact all members or groups of members. The table below highlights survey results from the 2013 CAHPS Member Satisfaction Survey.

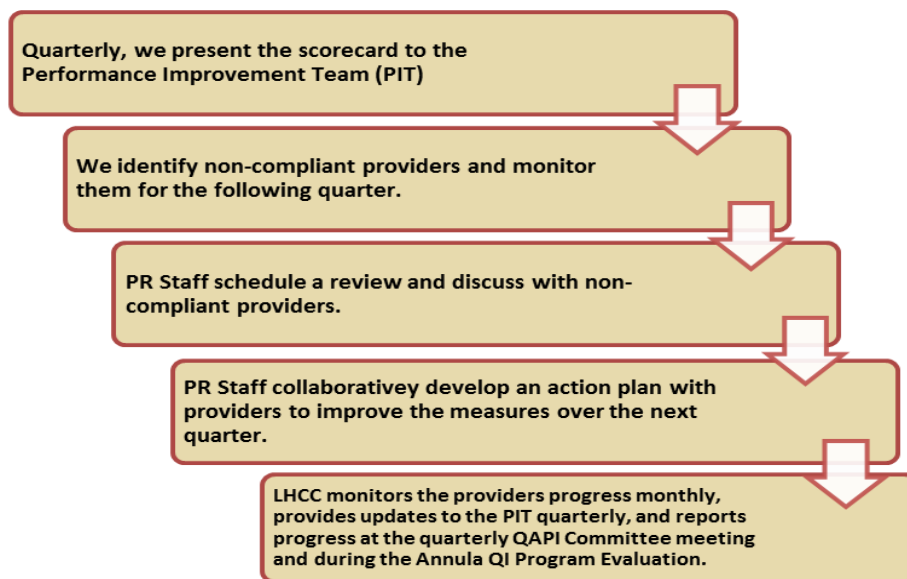
Composite	LHCC Rate	Threshold Percentiles
<b>CAHPS Adult</b>		
Getting Needed Care	74.7%	50th
Getting Care Quickly	77.3%	25th
<b>CAHPS Child</b>		
Getting Needed Care	81.2%	75th
Getting Care Quickly	90.3%	75th

External Quality Review Organization (EQRO) Surveys. Based on our LA EQRO Annual Compliance Review September/October 2013 report results, we performed:

- **Full Compliance** related to Section 7.1.15.1, Accessibility of Access and Services
- **Minimal Compliance** related to Section 7.1.15.7, Monitoring Provider Compliance

While we understand meeting appointment accessibility and wait time standards are a challenge for many practices in Louisiana, we continuously enhance our monitoring processes and provider and member outreach strategies to ensure we support our providers and members in providing access to the services needed in a timely manner.

Improvements Implemented Based on Survey Results. *New Monitoring Process.* In September 2013, we implemented a new monitoring process using a scorecard to summarize provider compliance with monitored measures, as required by LHCC’s PRVR 04 Provider Appointment Accessibility Standards Policy.



***Analysis of Emergency Room (ER) Utilization Data Indicating Access Issues.*** In 2013, we created a task force consisting of representation from Provider Relations, our Case Management Team, our MemberConnections™ team and Finance to ensure access issues were addressed. Members of our task force pull reports from our **Centelligence™** Enterprise Data Warehouse (EDW), which receives, integrates and transmits internal and external administrative and clinical data. Our task force tracks and follows up on frequent ER users and assigned primary care providers to identify potential barriers to PCP accessibility. Our MemberConnections™ Representatives (MCRs) outreach to identified members needing intervention. In addition, our PR Specialists distribute ER reports to PCPs to make them aware of members who are frequently visiting the ER and encourage them to outreach to their patients to help identify barriers to obtaining care in their office. We also help coordinate transportation and other care needs in order to ensure access.

***Performance Improvement Plan (PIP).*** In 2012, we initiated a PIP related to reduction of inappropriate ER utilization and implemented a task force and a pilot during the 3rd and 4th quarters of 2012. The task force defined the target population for this PIP as members who had 3 or more ER visits within the last 90 days of the measurement period. These reports listed identified members; the assigned PCP; and information such as number of visits, member identification and contact information, diagnosis, and whether the member is enrolled in LHCC's Case Management or a Chronic Care Management Program.

In 2013, 75 providers with high ER utilizers were stratified and targeted for outreach, education and intervention by Provider Relations or PCMH staff. We contacted the providers (which included FQHCs, Medical Home eligible providers, and other PCPs), provided information on their ER rates, and encouraged them to outreach to identified patients and open their office schedules to accommodate them.

Total number of ER visits comparing Q1 2012 to Q1 2013 for members assigned to FQHCs decreased by 50%

Total number of ER visits comparing Q1 2012 to Q1 2013 for members assigned to PCMH providers decreased by 65%

Members in the "other" subset of the total group decreased the total number of ER visits by 45%

LHCC conducted an analysis of ER utilization for Q1 2012 compared to Q1 2013 with impressive results as shown to the right. Although our PIP is finalized, LHCC staff will continue to work on the project throughout 2014, and we expect to see a continued decrease in the ER rate due to members appropriately accessing appointments for needed care.

### Provider Value Added Incentives and Services to Support Access/Availability

#### LHCC in Action...

*"As you are aware several FQHCs were closely partnered with LHCC during its early development. Although those specific relationships have evolved, they continue to provide a foundation for ongoing collaborations to identify areas for improvement; and further enrich quality and services through education, data sharing, and incentives. These efforts not only increase access but provide it within a more effective structure through an emphasis on quality."*

Jonathan Chapman, Louisiana Primary Care Association, Inc., Executive Director

Physicians sometimes limit their hours of operation or use an appointment restriction approach as a way to keep appointment and wait time problems caused by their patients under control. Others have expressed concern and frustration regarding patients who routinely miss appointments. At LHCC, we believe cooperation and communication among our plan, our members, and our providers must exist in order to resolve these issues. To proactively encourage the expansion of appointment availability, reduce wait times and increase access to care, we instituted four important value added incentives and supports for our providers:

- **ER Reduction:** LHCC offers all PCPs an additional PMPM incentive related to managing emergency utilization as described in Section Z.1. In addition, LHCC offers key medical groups and health systems the opportunity to participate in "gain share" compensation models. Through these gain share models, LHCC shares savings resulting from offsetting reduction to ER or Urgent Care services with providers participating with the program. This *model supports the expansion of appointment availability* as a deterrent to inappropriate ER and urgent care visits.
- **Extended Hours:** To further encourage access to care and expand appointment access, and to offset the expenses of providing services after normal business hours, LHCC offers enhanced reimbursement to PCPs who offer extended appointment hours.
- **Missed Appointments Follow Up:** LHCC requests that PCPs inform our MemberConnections™ department when a LHCC member misses three or more appointments so we can monitor these events in our system and provide outreach and education to the member on the importance of keeping appointments. Our MCRs located in each regional office assist our Case Managers/Health Coaches with coordination of care needs such as scheduling appointments and transportation; conducting outreach efforts; and educating high risk members regarding Case Management/Chronic Care Management services. They also assist our providers in helping to reduce missed appointments, and reduce the inappropriate use of ER services by high risk members who do not access care (such as preventive services) appropriately.
- **NurseWise®:** LHCC's 24/7 nurse advice line helps members proactively manage their health needs, decide on the most appropriate care and setting, and encourage members to talk with their physician about preventive care. If members are unsure as to the urgency or emergency of the situation, NurseWise encourages the member to contact their PCP and/or NurseWise for assistance.

## *H.2 Describe your provider grievance and appeal process.*

### **Overview**

Louisiana Healthcare Connections (LHCC) maintains a formal Grievance System in compliance with all DHH contractual and regulatory requirements, all applicable State and Federal requirements including but not limited to 42 CFR Part 438, Subpart F, as well as NCQA Accreditation Standards. The Grievance System includes a member grievance process, member and provider appeal process, and member state fair hearing process (once LHCC's appeal process has been exhausted). Our Provider Complaint System, described in H.3 includes provider grievances (treated as complaints) and claim dispute and arbitration process. Our written Grievance System policies and procedures address processes for the receipt, acknowledgement, investigation and timely resolution, and documentation of grievances and appeals. LHCC considers the Grievance System to play a critical role in serving our members and holding ourselves accountable and we are committed to making it a fair process, conducted with diligence and integrity to ensure that we are responsive to our members and that they are being served appropriately.

LHCC's Grievance System falls under the responsibilities of our Quality Improvement Department and is supported by both our Utilization Management and Provider Relations Departments. All appeals are directed to our Grievance and Appeals Coordinator (G&A Coordinator) who reports to our Clinical Appeals Supervisor and ultimately to our Senior Director of Quality Improvement. The G&A Coordinator documents receipt of the provider appeal in our Appeals Log and our Clinical Appeals Coordinator documents the investigation and resolution in TruCare (described below). Our G&A staff monitor trends and resolutions; and assist in preparing G&A reports that are submitted to the State and to our Quality Assessment and Performance Improvement Committee.

Our processes for handling member appeals and provider appeals are similar; differences between the two processes are noted in our response below. For purposes of both this response and our internal processes, LHCC uses the following definitions:

- **Action:** For purposes of this definition an Action is defined as:
  - The denial or limited authorization of a requested service, including the type or level of service; or
  - The reduction, suspension, or termination of a previously authorized service; or
  - The failure to provide services in a timely manner, as defined by Section 7.3 and Section 7.5 of this RFP; or
  - The failure of the MCO to act within the timeframes provided in Section 10.6.5 of this RFP.
- **Member Appeal:** a request for review of an action as defined above. Providers may submit an appeal on behalf of a member with the member's written consent regarding a medical necessity determination prior to the services being rendered. Member appeals are processed as expeditiously as the member's condition requires and in compliance with standard and expedited appeal processing timeframes. Members, or providers acting on behalf of a member, may request a State Fair Hearing after exhausting LHCC's internal appeals processes. A complete description of our member appeal process can be found in our response to Section S – Member Grievances and Appeal.
- **Provider Appeal:** Provider appeals are request for the reconsideration and reversal of a MCO's decision on a specific action or transaction such as the denial or reduction of a claim, the imposition of a penalty or recoupment of payment, the termination of a contract, etc.
- **Provider Grievance:** Provider complaints and grievances include the expression of provider dissatisfaction with general policies and actions of the MCO. Complaints may be received orally, via

phone, in writing or as submitted by DHH. A grievance is a complaint formally filed, in writing, with the MCO according to procedures established by the MCO.

- **Provider Claim Dispute:** internal process for providers to file a dispute regarding denial or underpayment of a claim or group of claims. A claims dispute is one type of provider appeal. It is a formal process for a provider to seek payment or adjustment of payment for a specific individual claim.

In our response to H.2 Provider Grievance and Appeals we have described our Provider Grievance process, Provider Appeal of Medical Necessity process, Claim Dispute process (which includes claim appeals) and our process for Non-Service related appeals such as appeal of a credentialing or contracting decision.

### System to Capture, Track and Report Status and Resolution

LHCC uses TruCare, our fully integrated state-of-the-art medical management documentation and authorization system, to support our utilization review and to track appeals that include a clinical component. Users can electronically assign “owners” to a request, and transfer requests automatically to appropriate staff for review. For example, the G&A Coordinator routes appeals requiring medical necessity review to our Clinical Appeals Coordinator who may then route the request to a physician advisor for second level review. All entries are date and time stamped with the user’s electronic signature allowing us to monitor and report on aging and resolution of appeals at each step of the process. Automated Workflow Distributor (AWD) is our claims work flow management system to support efficient processing of pending and disputed claims. Similar to TruCare, AWD allows LHCC staff to attach supportive documentation and electronically assign “owners” to investigate and resolve claim disputes including reconsiderations, appeals and requests for arbitration; entries are date and time stamped.

**Records Maintenance.** LHCC retains records of all grievances and appeals including logs and records of disposition for at least six years. For grievances and appeals under any litigation, claim negotiation, audit or other action involving the documents or records has started before the six year period; LHCC will retain the records until completion and resolution of such action or the end of the regular six years, whichever is longer.

### Provider Grievances

LHCC processes a provider grievance as a provider complaint except that a grievance must be formally submitted in writing while a complaint may be submitted by mail, fax, telephonically or in person. In order to prevent redundant narrative, we are providing a brief description of the grievance process here with a more detailed explanation of the complaint/grievance process provided in our response to H.3 Provider Complaint System, below. Providers must submit a grievance in writing. All provider grievances are documented in CRM, our innovative member and provider services inquiry, tracking, workflow, and data management system and any associated documentation is attached. In addition, the Provider Complaints Coordinator maintains a Provider Complaint/Grievance Log which serves as our primary source for tracking and reporting and is populated with all of the data fields needed to meet DHH monthly reporting requirements. Provider grievances are electronically routed in CRM to our designated Provider Complaint Coordinator (Complaint Coordinator) who has the authority to administer the provider complaint process including acknowledgement, investigation and resolution. The Complaint Coordinator will provide an acknowledgement of the complaint to the provider within 3 business days of receipt. The Complaint Coordinator gathers all pertinent facts and coordinates with a Provider Relations Specialist to complete a thorough investigation of the complaint using applicable statutory, regulatory, contractual and

provider subcontract provisions and applying LHCC's written policies and procedures. LHCC strives to resolve complaints as soon as feasible with a goal of not more than 30 calendar days. If the complaint is not resolved in 30 days, the Complaint Coordinator documents and notifies both the provider and DHH of the outstanding issues, including a timeline for resolution and reason for the extension of time. All complaints should be resolved in no more than 90 days of receipt.

### **Provider Medical Necessity Appeal Process**

A provider may submit an appeal regarding a medical necessity determination *for services the member has already received* and for which no claim has been processed, without member consent. Provider appeals will not be processed under an expedited timeframe because the services have already been rendered. Provider appeals cannot be elevated to a State Fair Hearing; however, providers may avail themselves the Claims Dispute process as described below.

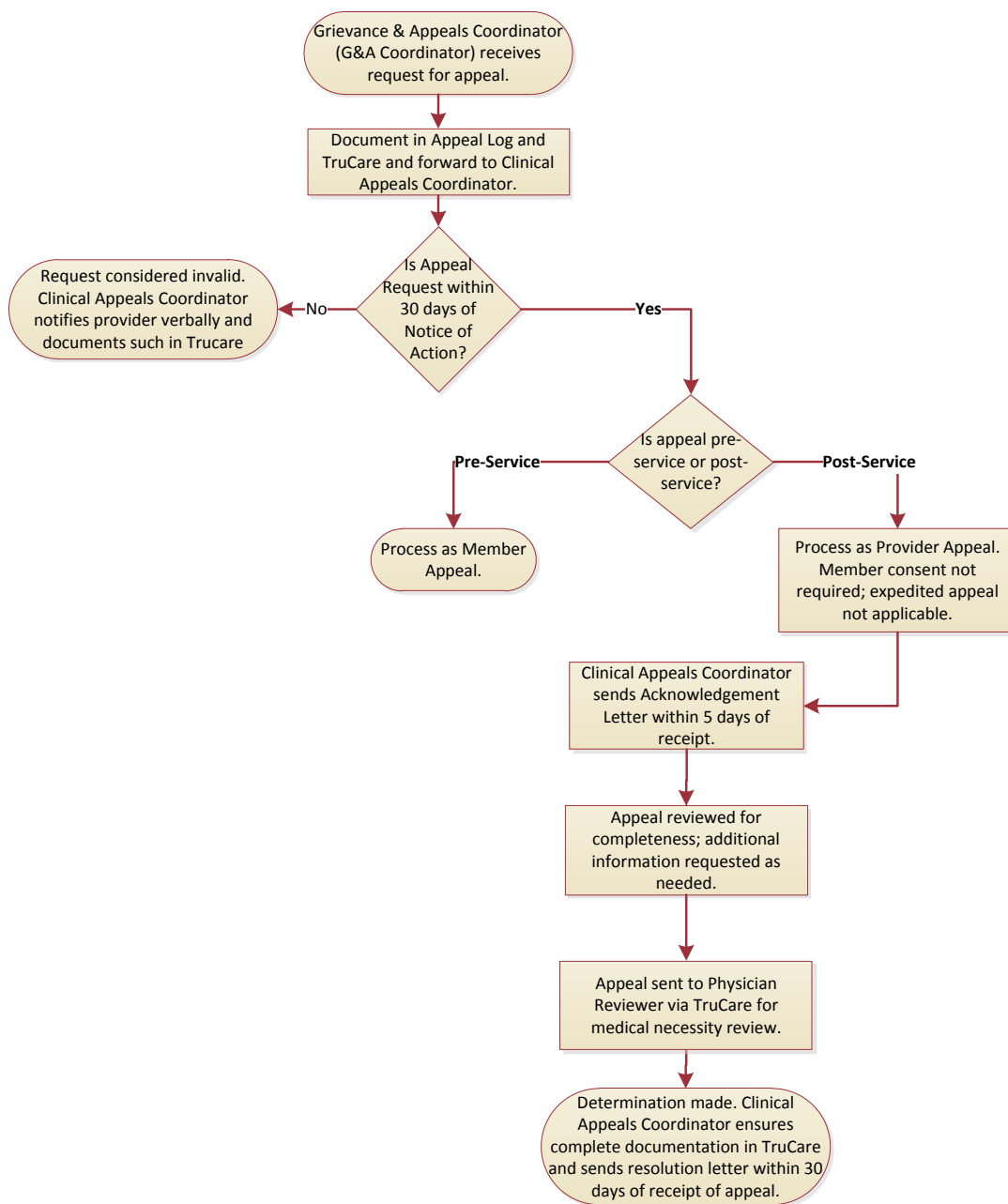
**Receipt and Acknowledgement of Provider Appeal.** Similar to our member appeal process, LHCC allows up to 30 calendar days from the date of the Notice of Action for a provider to submit an appeal for services that have already been rendered. Providers, whether in or out-of-network, may submit an appeal by fax, mail, or telephone; oral requests must be followed up in writing. LHCC considers the oral receipt date as the initial receipt date of the appeal. Upon receipt, the G&A Coordinator logs the provider appeal in TruCare noting the date of receipt, route of receipt, appeal category, and uploads any additional information submitted with the appeal request. The Clinical Appeals Coordinator sends the provider a written acknowledgement of the appeal and notifies the provider of their right to submit additional information in person or in writing. LHCC also allows the provider the opportunity to examine the case file, including medical records and any other documents considered during the appeals process.

**Review and Resolution.** The Clinical Appeals Coordinator reviews the provider's appeal to determine if the appeal was submitted within the allowed timeframe. If the date of the appeal is greater than 30 calendar days from the date of the Notice of Action, the appeal is considered invalid and the provider is notified verbally that the appeal was not received within the appropriate time frame as noted in the original denial letter. This conversation is documented in TruCare.

If the appeal is within the submission timeline, the G&A Coordinator routes the appeal request along with any additional information submitted by the provider to the Clinical Appeals Coordinator for review. The Clinical Appeals Coordinator completes a first level review to determine if the additional information submitted supports medical necessity for the services requested and will request additional clinical documentation if needed. If the request for service does not meet medical necessity review, the Clinical Appeals Coordinator routes the appeal request and supporting information to a physician reviewer for second level review. The physician reviewer determining an appeal based on lack of medical necessity will be a healthcare professional with appropriate clinical expertise in treating the member's condition who was not involved in any previous level of review or decision making regarding the services that are the subject of the appeal. The Clinical Appeals Coordinator and/or physician reviewer completes the review, documents the decision in TruCare. The Clinical Appeals Coordinator reviews the appeal for completeness, completes the TruCare documentation, and mails the appeal resolution letter to the appellant within two business day of the decision, not to exceed 30 days from submission of the appeal. The Clinical Appeals Coordinator initiates any follow-up action that results from the decision, such as payment, including for disputed services the member received while the appeal was pending.

**Provider Medical Necessity Appeal Process.** Please see the following page for a flowchart illustrating the steps in LHCC's Provider Appeal Process.

**Chart H.2.a: Provider Medical Necessity Appeal Process**



## Claim Dispute Process

LHCC has implemented an internal process for providers to file a dispute regarding denial or underpayment of a claim or group of claims. LHCC's claims dispute process includes three levels: 1) request for reconsideration, 2) claim appeal and 3) arbitration. A provider must request reconsideration before requesting a claim appeal. Both a reconsideration and claim appeal must be submitted in writing within 90 days of the date of notification of adjudication. Providers may file for reconsideration by resubmitting the claim (with medical records) indicating on the claim, in the appropriate field, that the claim is being submitted for reconsideration. A claim appeal must be submitted on a Claim Appeal Form and providers must include any additional clinical or administrative correspondence with the request. The claims dispute process is managed by our Claims Processing Center. The claims center systematically captures all claim disputes and resolutions including maintenance of supporting documentation in Automated Workflow Distributor (AWD).

For administrative disputes such as member eligibility and claim edits, the Claims Specialist will review and make a determination regarding the dispute. If the dispute involves an authorization or lack of authorization, the Claims Specialist will route the appeal via AWD to the LHCC Clinical Appeals Coordinator to review the provider's request. A written resolution of the claim dispute is mailed to the provider within 30 calendar days of receipt of the dispute including re-adjudication of the claim to a paid or denied status. If the provider is not satisfied with the decision of the claim appeal, the provider may request arbitration.

**Arbitration.** A provider, who has exhausted the claim reconsideration and appeal processes described above, has the option to select binding arbitration by a private arbitrator. LHCC, in agreement with the provider, will engage a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution and has experience and expertise in the health care field. The rules of the American Arbitration Association will apply if LHCC and the provider are unable to agree on an association. Unless otherwise agreed upon between LHCC and the provider, the arbitration hearing and final ruling will occur within 90 days of selecting the arbitrator. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

## Appeal of Credentialing Committee Decisions

In addition to the medical necessity and claim appeal processes described above, LHCC has policies in place that enable providers to appeal a decision made by LHCC's Credentialing Committee. A provider has the opportunity to request an appeal in the event the Credentialing Committee recommends termination, revocation or suspension of the practitioner's network participation for reasons relating to the competence or professional conduct of the practitioner, or in the event the practitioner is entitled by law to an opportunity for an appeal. In the event the Credentialing Committee recommends termination, revocation, or suspension of the practitioner's network participation for reasons relating to utilization review standards, measures, policies, rules or regulations of LHCC, or pursuant to the terms of the practitioner's Provider Contract, the Credentialing Committee may, at its discretion, afford the practitioner the opportunity for an appeal hearing. Providers must submit the request for appeal in writing within 30 days of the notice of Committee's decision addressed to our Chief Medical Director (CMD). Upon receipt, the Quality Improvement designee logs the appeal in our Credentialing Appeal Log and sends a letter to the provider acknowledging receipt of the request and that an appeal hearing will be scheduled within 60 days. The CMD will assemble an Appeals Committee to hear the provider's appeal and make a determination. The Appeals Committee is comprised of a minimum of three (3) network practitioners, at least one who is in the same specialty as the practitioner under review. The Appeals Committee will not include members who: are in direct economic competition with the practitioner; are in business with the practitioner; or have previously made a recommendation or decision regarding the practitioner's network participation. Written notice of the decision is given to the practitioner in an

expeditious and appropriate manner but no more than sixty (60) days following the determination, and includes a statement containing specific reasons of the basis of the decision. The action of the Appeals Committee regarding any restriction, suspension, or termination matter is final. A copy of all proceedings will be maintained in the providers credentialing file.

### **Informing Providers about the Grievance and Appeal Process**

We educate providers and subcontractors about the Member and Provider Appeal process and the differences between each at the time of contracting; through our website, Provider Handbook, Provider Newsletters; during Provider Orientation; and through contact with Provider Relations/Services and Contracting staff. Out of network providers are informed about our provider appeal process on the remittance advice.

### **Tracking and Reporting Provider Appeals**

Through the use of TruCare and AWD, LHCC's staff are able to easily locate information for a provider calling to check on status and to effectively monitor the status of all appeals to ensure that timeframes are met. In addition, the G&A Coordinator maintains a Grievance and Appeal Log which serves as our primary source for tracking and reporting and is populated with all of the data fields needed to meet DHH monthly grievance and appeal reporting requirements. On a quarterly basis, appeal tracking and identified trends are submitted to the Quality Assessment and Performance Improvement Committee for review and recommendations for interventions or additional action.

***H.3 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.***

### **Overview**

Louisiana Healthcare Connections (LHCC) has built our health plan on strong provider relationships that have improved provider satisfaction as our program has matured and providers have become accustomed to new processes and policies resulting from the transition from DHH to LHCC policies and processes. We have worked collaboratively with providers to design, monitor and improve all aspects of plan operations, including strong service support for providers. LHCC goes the extra mile to provide excellent customer service, education and support to our providers and it shows in the satisfaction of our providers. LHCC's Provider Complaint System is overseen by the Vice President of Network Contracting and Provider Relations who has executive authority to require corrective actions. We will provide DHH with contact information for this designated executive within one week of contract approval and within two business days of any change. LHCC has a designated Grievance and Appeal Coordinator who serves as the Provider Complaint Coordinator to receive, track and process provider complaints including those from both in-network and out-of-network providers. Our written policies and procedures will comply with State and federal regulations as well as Contract and DHH's requirements for accepting and managing provider inquiries, complaints and requests for information, including but not limited to the requirements set forth in Section 10.6 Provider Complaint System and will be submitted to DHH for review and approval within 30 calendar days of the date the Contract is signed with DHH. LHCC treats claims disputes and grievances like a complaint in accordance with DHH requirements for the Provider Complaint System. Our processes for handling inquiries and requests for information are similar; differences between the two processes are noted in our response below. For purposes of both this response and our internal processes, LHCC uses the following definitions:

- **Provider Inquiry:** A question from a provider (regardless of method of receipt) that does not meet the definition of a complaint but is related to a specific member, claim or action
- **Provider Request for Information:** A question from a provider that is more general in nature, such as a payment policy or request for a manual or form and does not pertain to a specific member, claim or action
- **Provider Complaint:** any verbal or written expression, originating from a provider and delivered to any employee of LHCC, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by LHCC, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Complaints may be received orally in person, via phone, in writing or as submitted by DHH.
  - For purposes of this definition an action is defined as:
    - The denial or limited authorization of a requested service, including the type or level of service; or
    - The reduction, suspension, or termination of a previously authorized service; or
    - The failure to provide services in a timely manner, as defined by Section 7.3 and Section 7.5 of this RFP; or
- The failure of the MCO to act within the timeframes provided in Section 10.6.5 of this RFP.
- **Provider Claims Dispute:** A formal process for a provider to seek payment or adjustment of payment for a specific individual claim
- **Provider Grievance:** A formal written expression, originating from a provider and delivered to any employee of LHCC, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by LHCC, excluding request of reconsideration or appeal for specific individual claims. A grievance is a complaint formally filed with LHCC according to procedures established by LHCC.

### **System to Capture, Track and Report Status and Resolution**

Customer Relationship Management (CRM) is our innovative member and provider services inquiry, tracking, workflow, and data management system. All individual provider interactions, including telephonic, face-to-face, fax, email, or surface mail are documented in CRM, which also serves as our system to track and maintain pertinent facts and documents regarding provider complaints. Provider interactions are assigned a “call type and sub-type” category for identification, tracking and monitoring purposes. Examples of these categories include *Provider Updates/Status Information* for inquiries related to provider status and demographics, provider number, TIN or NPI information; *Provider Requests* for information related to requests for manuals, copies of Explanation of Payment forms, and check copies or requests for a Provider Relations Specialist visit; *Provider Education* for inquiries related to requests for support with the claims submission, Electronic Data Submission, Electronic Funds Transfer or Authorization processes and *Provider Complaints* regarding any issue that expresses dissatisfaction with a policy, procedure or any other communication or action by LHCC. All entries are date and time stamped with the user’s electronic signature allowing us to monitor and report on aging and resolution of complaints. Staff are able to generate letters, route tasks to other departments and create reminders to ensure adherence to process timelines.

### **Receipt of Inquiry, Complaint or Request for Information**

Providers may make an inquiry, complaint or request for information via telephone, electronic mail, surface mail, and in person. Our toll-free Provider Call Center, located in Baton Rouge, is staffed Monday through Friday, 7:00 a.m. to 7:00 p.m. Central Standard Time by Provider Service (PS) staff.

Additionally, LHCC employs Provider Relations (PR) staff who interact with providers face-to-face in their offices. These staff are fully trained on operational policies and procedures including credentialing, billing, and claims processing. Provider staff are also trained in recognizing the difference between a provider complaint and a member grievance or appeal in which the provider is acting on behalf of the member.

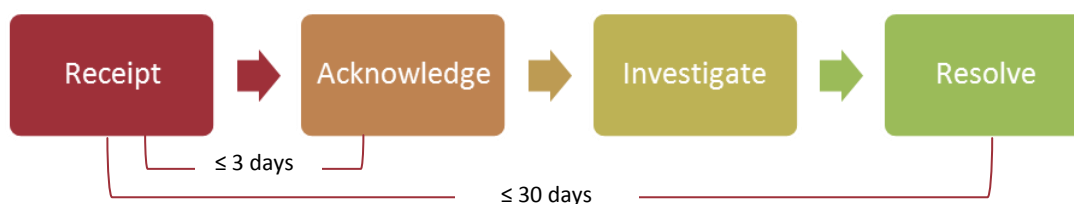
**Verbal Requests.** Both PS and PR staff are able to respond to and resolve provider inquiries and requests for information. Our provider call center and field staff are also able to handle most claims inquiries. Complaints may be received by either our PS representatives or PR Specialists who will log the complaint in CRM. Our provider staff will attempt to answer questions or resolve complaints received in person or by phone during the conversation. If an inquiry or request for information cannot be resolved during the discussion, the provider staff member will inform the provider that additional research is necessary and that they will receive a response as soon as possible. If the issue is a complaint, it is sent through CRM to the Provider Complaint Coordinator, who logs the complaint and forwards for additional research, as described below.

**Written Requests.** LHCC's Provider Service Representatives are responsible for responding to written requests from providers, including those received by email through the Provider Portal, fax or surface mail. All issues, regardless of type are documented in CRM and any associated documentation is attached. Inquiries and requests for information are responded to by PS staff. If the correspondence is a complaint or grievance, the PS staff enter the information in CRM and forward it to the Provider Complaint Coordinator. A Provider Relations Specialist may also directly receive an email from a provider. PR staff may research this issue, regardless of type. All complaints, regardless of how they are received, including those resolved during a verbal discussion, are electronically routed through CRM to our designated Provider Complaint Coordinator (Complaint Coordinator) for tracking and reporting purposes.

### Acknowledgement, Investigation and Resolution

LHCC realizes that we are able to limit the timeframe for submission of complaints to 30 days from the date of occurrence; however, LHCC has decided not to impose a timeframe for which providers can submit complaints, at this time. As noted above, our provider staff will route provider complaints to our designated Provider Complaint Coordinator who has the authority to administer the provider complaint process including acknowledgement, investigation and resolution.

**Figure1. Provider Complaint Process**



LHCC's Provider Complaint Coordinator will document and track all steps of the complaint process in CRM (The Provider Complaint Coordinator also maintains the Provider Complaint Log which is where they track the complaint for DDH reporting purposes). The Complaint Coordinator will provide an acknowledgement of the complaint to the provider within three business days of receipt. The acknowledgement is given in writing and notifies the provider of the opportunity to submit additional information and to present their case in person. The Complaint Coordinator gathers all pertinent facts and coordinates with a PR Specialist to complete a thorough investigation of the complaint using applicable

statutory, regulatory, contractual and provider subcontract provisions and applying LHCC' written policies and procedures. This may include, but is not limited to, reviewing the provider's CRM contact log and researching presence and status of prior authorizations, claims submissions, or credentialing applications. To ease provider hassle, complaints involving multiple claims that involve the same or similar payment or coverage issues may be bundled together, regardless of the number of patients or claims involved. The investigation may also include interviewing the provider and/or LHCC staff for more information. After complete investigation, the Complaint Coordinator, working with the PR Specialist, determines a decision or resolution. The Provider Complaint Coordinator will send a Resolution Letter within 5 business days of the resolution. LHCC strives to resolve complaints as soon as feasible with a goal of not more than 30 calendar days. If the complaint is not resolved in 30 days, the Complaint Coordinator documents and notifies both the provider and DHH of the outstanding issues, including a timeline for resolution and reason for the extension of time. All complaints should be resolved in no more than 90 days of receipt.

### **Training Staff and Educating Providers**

**Staff Training.** LHCC staff receive extensive education and training on health plan policies, procedures and processes. This includes information on our Grievance and Appeal System and our Provider Complaint System and differences between provider complaints and grievance or appeals submitted by a provider on a member's behalf. Training occurs upon initial hire, change in policy and at least annually using written and face-to-face techniques. All policies and procedures, training materials and tools needed to perform day to day functions are maintained within LHCC's Knowledge Center, an internal SharePoint site serving as our knowledge management system. This holds workflows, job aids, lists, fact sheets etc. that the plan uses. The users consist of Provider Relations, Member/Provider Services, Medical Management, and Training.

**Provider Education.** We educate providers and subcontractors at the time of contracting; through our website, Provider Handbook, Provider Newsletters; during Provider Orientation; and through contact with Provider Relations/Services and Contracting staff. Specifically, our Provider Handbook includes a description of the Provider Complaint System with specific instructions on how to contact our Provider Call Center and Provider Relations staff and contact information for our Complaint Coordinator. The Handbook also educates providers on their ability to obtain a hard copy of our Provider Complaint System policies from LHCC at no charge to the provider. We make non-contracted providers aware of our Provider Complaint System policies and procedures through our website and as part of the remittance advice mailing. LHCC values our Providers and does not take punitive action against or terminate contracts with providers who file a complaint, grievance, or appeal (including on a member's behalf).

### **Tracking, Monitoring and Using Data**

LHCC will perform on-going monitoring of provider complaints, tracking turn-around-times to ensure the issuance of timely resolutions as well as conducting periodic internal data integrity checks to ensure the appropriate applications of regulations. LHCC's CRM system will serve as a mechanism to capture, document and track the status and resolution of all provider complaints whether received by telephone, in person, or in writing, and will include all associated documentation. Through use of the CRM system, LHCC is able to easily locate information for a provider calling to check on status and to effectively monitor the status of all complaints to ensure that timeframes are met. In addition, the Provider Complaints Coordinator maintains a Provider Complaint Log. The Provider Complaint Log serves as our primary source for tracking and reporting and is populated with all of the data fields needed to meet DHH monthly complaint reporting requirements.

On a quarterly basis, provider complaint tracking and identified trends are submitted to the Quality Assessment and Performance Improvement Committee (QAPI Committee) for review and

recommendations for interventions or additional action. For example, we noted a spike in provider complaints regarding claims processing. Our Complaint Coordinator investigated further and found that a global claims adjustment error had occurred (ACA payments did not match the EOP) and worked with the Vice President of Network Contracting and Provider Relations to develop and distribute a provider fax blast acknowledging the error, explaining the status and timeframe for resolution and, offering a spreadsheet of all overpayment and recovery information to assist the provider in their payment reconciliation processes. The QAPI Committee will track any implemented interventions, responsible parties, and outcomes which may include the development and intervention of a corrective action plan (CAP) and monitoring of the CAP through resolution.

***H.4 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.***

***o Submit sample quality profile reports used by you, or proposed for future use (identify which). o Describe the rationale for selecting the performance measures presented in the sample profile reports.***

***o Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.***

## **Introduction**

The Louisiana Healthcare Connections (LHCC) Provider Profiling Program increases provider awareness of performance, motivates providers to establish measurable goals relevant to our members, identifies best practices of high performing providers, identifies opportunities for provider improvement, and facilitates MCO-provider collaboration in the development of clinical improvement initiatives. Our Profiling Program directly supports the LHCC focus on the “Triple Aim,” a framework developed by the Institute for Healthcare Improvement and adopted by CMS to optimize health system performance. LHCC has embraced the Triple Aim concept, including the belief that all of our efforts to engage and support providers must simultaneously address the three critical dimensions of health care improvement:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

LHCC understands and will comply with all DHH requirements for provider profiling, including, but not limited to Section 8.12. PCP Utilization and Quality Profiling, and Section 8.13. PCP Utilization and Quality Profile Reporting Requirements. In addition to profiling providers and analyzing the data to identify utilization and/or quality of care issues, we also consider profiling results in the re-credentialing process (Section 7.9.5.6), and when monitoring the medical appropriateness and necessity of healthcare services (Section 8.2.2.2). Our Quality Assessment and Performance Improvement Committee (QAPI Committee) has responsibility for overseeing provider profiling (Section 14.2.2.6).

## **Provider Profiling Approach**

LHCC’s corporate strategy to increase provider engagement includes collaboration with provider members of our Quality Assessment and Performance Improvement Committee (QAPI Committee) and, as needed, Provider Advisory Committee, to jointly develop our approach and ensure the profiling process has value to providers, members, and the plan. We will work closely with our providers to select profile indicators, build useful analyses, and help providers use feedback to improve care. We align these indicators with our financial and non-financial incentives to encourage continuous improvement. Our

profiling approach aligns with recommendations from the AMA Physician Consortium for Performance Improvement, NCQA, and the National Quality Forum.

**Centelligence™ Analytics.** To ensure the best possible results, we will use both plan and Centene analytic capabilities for profiling, since effective improvement requires complex analysis and feedback at several levels of the care process. We use Centelligence™, our integrated business intelligence platform, to power our Provider Profiling Program and generate profile reports. Centelligence™ integrates information from various internal and external sources to produce actionable information. It provides decision support tools for operational, clinical, and compliance purposes, including the generation of HEDIS quality measures, and identification of gaps in recommended care and health risks. Centelligence™ uses predictive modeling that has been customized for the Medicaid population to generate risk profiles of our Members, and complex algorithms to severity-rank episodes of care. Its ability to adjust for risk and generate provider-level performance reports makes it a powerful tool to help providers better manage their patients and to help LHCC improve overall population health.

**Profile Reports.** Our *PCP/OBGYN Profile Reports* will provide a monthly look at provider performance on select HEDIS and non-HEDIS quality measures compared to benchmarks. Our supplemental *Patterns of Care Reports* for high volume providers will provide a quarterly look at risk-adjusted utilization/cost and quality performance compared to specialty-specific peers. In addition, LHCC's Pharmacy Department is developing a *Pharmacy Report* that will provide a quarterly look at performance on key pharmacy quality measures.

**PCP/OBGYN Profile Reports.** We will initially generate and distribute profiling reports for PCP and OB/GYN providers.

Our *PCP Profile* will contain two components:

- A PCP HEDIS Report that views performance on a set of HEDIS quality measures compared to benchmarks
- A PCP Dashboard Report that is aligned with our new PCP incentive program, and views performance on select HEDIS, access to care, and utilization quality measures compared to benchmarks. This report also includes a timely list of panel members with gaps in recommended preventive care services.

PCMH recognized practices will receive the PCP Profile Report, but with higher goals that reflect best practices for PCMH providers. Premier providers will receive a PCP Dashboard Report with at least one additional performance measure. Premier providers are those most willing to engage with our members and coordinate their care with LHCC's Case Management Programs.

Our *OB/GYN Profile*, will align with our new OB/GYN incentive program and include select women's health and obstetric quality measures compared with benchmarks.

**Patterns of Care Reports.** Our *Patterns of Care Reports* will supplement the PCP and OB/GYN Profiles for high volume PCPs and high volume OB/GYN providers, providing more detailed and actionable performance data for these more sophisticated providers. We will produce specialized Patterns of Care Reports for pediatric, internal medicine, and family medicine PCPs with performance measures that are relevant for the services that they each provide.

**Pharmacy Reports.** Our *Pharmacy Reports* will include indicators such as the generic prescribing rate, average cost per prescription, and percent of prescriptions requiring prior authorization, along with specialty and network average benchmarks.

### **Determining Which Providers To Profile**

With input from the Provider Engagement Committee, the QAPI Committee, which includes PCPs and specialty providers, annually approves the provider types to be included in the Profiling Program; the inclusion criteria for individual (or group practice) providers; and the performance indicators to be measured. The QAPI Committee considers the average number of members served and the needs of enrolled members when determining provider types, as well as the quality indicators for each.

The QAPI Committee reviews program inclusion criteria annually to ensure that we include as many providers as possible in our Profiling Program, but will target those with sufficient panel size to allow statistically valid comparisons. In 2015, we will generate and distribute Profile Reports to all PCPs and OB/GYN providers who have the potential for participating in our provider incentive programs, and will generate and distribute Pharmacy Reports to all prescribing providers. We will generate and distribute Patterns of Care Reports to high volume PCPs with a total panel size of 250 or more members, and to high volume OB/GYN providers with 50 or more unique members seen per year.

### **Selecting Quality Indicators**

Each year, the QAPI Committee will approve quality indicators that provide a multi-dimensional assessment of performance using clinical and administrative data. Each indicator must be measurable, reliable, and valid; have available, reliable benchmark data; be relevant to our members, providers, and our QAPI Program; and be actionable by providers. To establish trends and assess improvement efforts over time, we measure the same indicators for multiple years whenever possible.

Our profiling reports for different provider types will include unique sets of indicators that are relevant to the services rendered by those providers; align with our provider incentive programs; and promote compliance with DHH expectations, evidence-based (CPGs), and national quality benchmarks.

### **Including Benchmark Data and Peer Comparisons**

Annually, the QAPI Committee will establish performance thresholds and improvement benchmarks for each selected indicator. The QAPI Committee may derive benchmarks from network-wide and specialty-specific data, the NCQA Medicaid 75th percentile, DHH goals for DHH incentive-based performance measures, or other credible published data. Our Profile Reports will compare provider performance on each indicator using these benchmarks. LHCC will disseminate all approved inclusion criteria, indicators, and benchmarks to providers annually through the Provider Newsletter and secure Provider Portal.

### **Data Analysis and Facilitating Improvement**

#### **Provider Engagement Committee**

Prior to distribution to providers, the LHCC inter-departmental Provider Engagement Committee will analyze individual and plan-level performance to confirm data validity, clinical relevance, and accurate data interpretation. The Chief Medical Officer will chair the Provider Engagement Committee and membership will include the Chief Medical Director and representatives from the Quality Improvement, Medical Management, Pharmacy, Network, and Provider Relations departments. The Committee will meet weekly initially, and then at least monthly to focus on performance, incentives, and other provider engagement areas. The Committee will analyze provider-level data to identify providers with the highest and lowest performance on the Profile Reports as well as the new Pharmacy Report. The frequency of the meetings will allow the Committee to respond rapidly to issues that are identified.

#### **Facilitating Improvement**

The PCP/OBGYN Profile Reports determine quality performance by assessing the number of eligible quality indicators for which the provider either meets specified goals or compares favorably or

unfavorably to peer or network benchmarks. The supplemental Patterns of Care Reports determine quality performance by comparing compliance for specific evidence-based quality rules relevant to the provider's attributed members to the compliance of the other same-specialty Providers for that exact same mix of rules. A Quality Index (the ratio of provider compliance to peer compliance) greater than 1 would indicate a compliance rate greater than peers for the exact mix of quality rules. A Cost Index is similarly determined that compares the provider's average costs for risk-adjusted episodes of care for attributed members to the average costs of peers with the same mix of episodes of care.

After PCP/OBGYN Profile and Patterns of Care Reports are generated, members of the Provider Engagement Committee, including the Chief Medical Officer and Provider Relations staff, meet face-to-face with Providers with overall low performance on PCP/OBGYN Profile Report measures. In addition, the Chief Medical Officer will meet face-to-face with each high volume provider with a Quality Index statistically significantly lower than peers, or a Cost Index statistically significantly higher than peers in Patterns of Care Reports. During these meetings, we will collaboratively develop a performance improvement plan with the provider.

Members of the Provider Engagement Committee also will meet with select providers with the highest performance to identify best practices that we can share with other providers. We will identify and solicit high-performing providers and respected regional sub-specialists to serve as **Champions** to advocate best practices within our network. We will share best practice information with all providers through provider orientations, the Provider Newsletter, and our secure Provider Portal.

**Network Management.** In addition to our Provider Profiling Program, our Network Development and Contracting staff (Network Team) will continue to monitor provider performance monthly and quarterly to identify providers of all types, including hospitals, with lagging performance and target them for education regarding quality, performance, and cost. The Network Team monitors indicators such as coding accuracy, overall cost compared to budget, volume of specialty referrals, inpatient admissions, and utilization of lab, radiology, and pharmacy, for example, for PCPs (in compliance with requirements in RFP Section 8.12). For hospitals, the Network Team monitors average inpatient length of stay and average cost per day, for example. The Network Team also monitors reports generated by Centelligence™ that, like Patterns of Care Reports, display risk-adjusted utilization/cost and non-preventive health quality performance compared to specialty-specific peers summarized by Quality and Cost Indices described in Facilitating Improvement above.

Similar to the process followed after the Profile Reports are generated, the Chief Medical Officer or Provider Relations staff meet with individual providers with low performance, including providers with a Quality Index statistically significantly lower than peers, or a Cost Index statistically significantly higher than peers, to collaboratively develop a performance improvement plan. They also will meet with select high performing providers, including those with a statistically favorable Quality or Cost Index, to identify best practices to share with other network Providers.

*o Submit sample quality profile reports used by you, or proposed for future use (identify which).*

For the PCP Profile Report, please see ***Attachment H.4-A Sample HEDIS Report*** for a sample proposed HEDIS Report, and ***Attachment H.4-B Sample PCP Dashboard Report*** for a sample of our proposed PCP Dashboard Report. For our proposed OB/GYN Profile Report, please see ***Attachment H.4-C Proposed OB/GYN Profile Report***. For samples of our Patterns of Care Reports for Pediatrics and OB/GYN, please see ***Attachment H.4-D Sample Pediatric Patterns of Care*** and ***Attachment H.4-E Sample OB/GYN Patterns of Care***.

*o Describe the rationale for selecting the performance measures presented in the sample profile reports.*

### **Multi-Dimensional Assessment**

LHCC selects profiling indicators within the Institute of Medicine’s framework for quality: safety, effectiveness, patient-family centeredness, timeliness, efficiency, equity, access, and care coordination, and with the goal of meaningful provider participation. Report indicators are credible to, and actionable by, providers. Our reports contain cost/utilization measures to indicate how efficiently the provider is using services. In addition, we include clinical quality measures, such as child/adolescent access to preventive care services and appropriate monitoring of diabetes, to measure, for example, how effectively a PCP provides and promotes access to key preventive health services, and complies with select CPGs and quality rules. These indicators may also measure the impact of certain clinical interventions. For example, we have included non-clinical indicators such as after-hours availability to measure medical home attributes. Since we expect the plan or peer average to improve over time, we anticipate continuously raising the performance bar for each indicator.

**Accurate and Measurable.** To ensure the accuracy and measurability of profile indicators, we use standardized HEDIS measures whenever appropriate. We may, however, modify the age and eligibility requirements, when appropriate, to ensure an adequate number of members for each indicator, and test custom profile indicators for accuracy and measurability before full implementation.

**Benchmark Data.** Established benchmark data is part of sound Quality Improvement methodology, and can be a strong motivating factor that appeals to a provider’s competitive nature. Benchmarks show providers how their members are doing and how their own performance compares to their peers. Performance measures that we select for our Profiling Program all have national Medicaid benchmark data, network-wide or peer group average scores, or DHH incentive-based performance measure goals.

**Relevance to Enrolled Population.** We include only those indicators that are relevant to our members and for the provider type profiled. For example, our HEDIS Report indicators will include child and adolescent preventive health measures, such as immunization status and well visits. Our OB/GYN Profile Report indicators will include women’s health measures, such as breast and cervical cancer screening, and caesarian section rate.

**Relevance to QI Initiatives, CPGs, and DHH Priorities.** The PCP/OB/GYN Profile Reports include indicators that measure compliance with CPGs, and are relevant to our QI initiatives. To focus on DHH priorities, our PCP Profile Report will include DHH incentive-based measures, such as adolescent well care and follow up for children prescribed ADHD medications.

***o Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.***

Each month, QI staff will generate and distribute both components of the PCP Profile Report to PCPs, and the OB/GYN Profile Report to OB/GYN providers meeting Profiling Program inclusion criteria, using rolling 12-month data with a three month claims lag. Providers may access Profile Reports on our secure Provider Portal, and we encourage providers to contact our Chief Medical Officer, or the Quality Improvement or Provider Relations staff, with any questions related to their profile reports.

Our Chief Medical Officer will personally deliver Patterns of Care Reports to high volume providers each quarter to discuss and help interpret the more complex performance indicators and indices within these reports. We expect to distribute our new Pharmacy Reports at least quarterly, also on the secure Provider Portal. To support continuous quality improvement, we engage providers throughout the reporting period. Frequent communication allows them to see how their scores are progressing over the year, and enables them to adjust their processes or approaches so they can positively impact their eligibility for incentives and/or recognition.

***H.5 Describe how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers. Identify the key requirements that will be addressed.***

## Overview

Louisiana Healthcare Connections (LHCC) understands the importance of initial and ongoing provider education, training and support related to billing requirements. We recognize providers have varying levels of billing expertise to support their claims submission processes, ranging from independent practice staff to formal centralized billing companies. Changes in billing requirements are often one of the most daunting and challenging for providers. In effort to provide consistency, our overarching philosophy is to emulate, as much as possible, the provider billing manuals of DHH's Fee-for-Service (FFS) Medicaid Program in order to minimize changes in the billing requirements from participating providers.

In 2013, we created a multi-faceted Provider Service Model in Louisiana to support providers with billing requirements and other provider related needs. Through this model, we designated Provider Relations (PR) the core department responsible for coordinating provider needs across the organization. Within PR, we developed specific employee skill sets such as certified coders and provider configuration staff to provide a more holistic approach to provider service, education, and claims resolution. By investing in the skill level of our local PR department, we are able to identify and support provider education needs more timely and thoroughly.

LHCC understands and will comply with all DHH requirements including, but not limited to, Section 7.15.1.7 Provider Education on Pharmacy and Claims Processing, Section 10.4.1.12 Provider Handbook, Section 10.5.3 Provider Education and Training, and all other contractual and regulatory requirements.

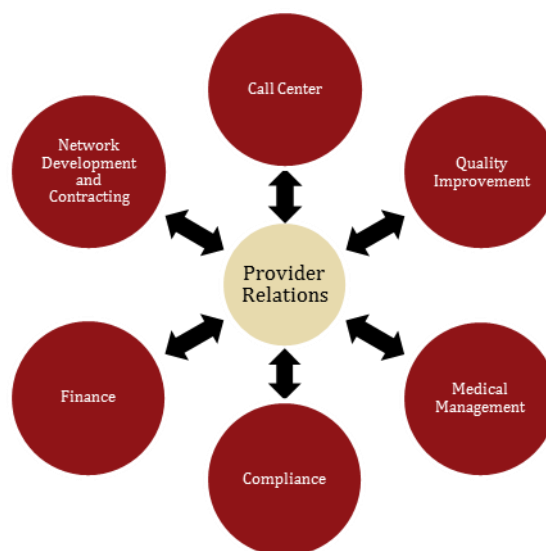


### Provider Service Model

**Structure.** LHCC’s provider service model structure provides a strong foundation with four functional roles for supporting providers, including, but not limited to the roles depicted in the graphic below.

Within our PR Team, we established these roles to increase support for our providers related to billing and other issues, and to allow our PR staff more quality time in the provider offices providing education.

Our internal PR staff handle research, analysis, and coordination of updates and provider needs related to billing with internal departments. This allows our external PR staff to take the time necessary to meet with the providers. While External PR Specialists provide face-to-face education and training to providers and billing staff about billing requirements, each of these areas within PR work together collaboratively to support provider billing needs in a timely and efficient manner.



We currently have certified coders in three areas within PR (CIA, CL, Internal PR Specialists) and our External PR Specialists plan to attend and complete CPC-P certification in 2015. With this skill set, we have experienced a positive impact in our ability to communicate with and respond to provider billing needs in a more efficient manner.

All four areas within PR have processes in place to ensure quality of the work performed respective to their roles. Each process within PR has an audit function to identify both training opportunities for staff and to ensure system accuracy via quality monitoring.

Our PR team meets regularly with each of the functional departments within our organization that support providers to ensure cross-functional communication, internal training and to address provider needs related to billing and related issues. The functional areas include:

- Network Development and Contracting
- Call Center
- Quality Improvement
- Medical Management
- Compliance
- Finance

LHCC provides all contractually required training to all providers and their staff, including specialized initial and ongoing training in accordance with Section 10.5.3 related to billing procedures and service authorization requirements for network providers who may have traditionally billed and obtained service authorization primarily from Medicaid and/or Medicare only. This training is currently being updated to include specific training for hospice and personal care service providers. We also provide ongoing training as deemed necessary in order to ensure compliance with program standards and the Contract.

## Initial Training

**Welcome Packet.** Within 14 days of completing initial credentialing, LHCC's PR department mails all new providers a Provider Welcome Packet. Our Welcome Cover Letter informs them how to obtain our Provider Manual, which includes details about LHCC's billing processes, via our website or how they can request a hard copy from us at no charge to the provider in accordance with Section 10.4.1. We also provide a copy of our Provider Manual on compact disc.

This packet contains all materials and addresses all of the information a provider requires to participate in LHCC's network, including the following which include information on a variety of topics. Some of the information regarding authorization, billing and incentives includes, but is not limited to

- Provider Manual (compact disc)
- Provider Quick Reference Guide
- Provider incentives and requirements
- Claims Dispute and Appeal Forms
- PaySpan Brochure (Information and registration for electronic transactions)
- Pregnancy Notification Form
- Prior Authorization Requirements
- Pharmacy Preferred Drug List
- Medical Prior Authorization Form
- List Copies of recent provider communication letters/newsletters/forms, particularly related to billing

**Provider Manual.** LHCC's Provider Manual, provided via compact disc in the welcome packet and available online through LHCC's provider portal, includes comprehensive content on provider billing and claims payment and serves as the best point of reference for provider billing and claims education. Billing and claims information available in the Provider Manual includes: general guidelines, clean claim and non-clean claim definitions, timely filing guidelines, electronic and paper claims submission instructions, electronic funds transfers (EFT) and electronic remittance advices (ERA), claim payment policies and processes and third party liability requirements.

**Initial Provider Orientation.** Within 30 days of a provider contracting with LHCC and completing the credentialing process, our External PR Specialists provide comprehensive general education on LHCC policies and processes. We conduct orientations in various ways, including but not limited to, individual meetings in the provider's office according to the provider's availability; group workshops in a community location such as a local hospital, FQHC or community center during several days and different times; and monthly Provider Webinars. In addition to general LHCC information, this initial orientation includes detailed information regarding billing and claims processing. As an incumbent Bayou Health plan, we have learned that educating new providers about general reimbursement, billing and claims payment information helps to create a baseline understand and to avoid potential questions or complaints. Information related to billing and claims included in the new provider orientation include:

- Provider Quick Reference Guide, which provides information about how a provider can receive claims assistance from:
  - Provider Service, for assistance checking a claim's status or to request training on a particular topic
  - LHCC's website through Provider Resources ([www.LouisianaHealthConnect.com](http://www.LouisianaHealthConnect.com)), to download an EDI Companion Guide or Provider Manual
  - LHCC's secure Provider Portal to look up a claim's status, review an Explanation of Payment (EOP), review payment history, or submit a claim
- Provider Manual, available electronically at [www.louisianahealthconnect.com/files/2012/01/FINAL-Louisiana-Healthcare-Connections-Provider-Manual-FINAL-09-131.pdf?fbd2e4](http://www.louisianahealthconnect.com/files/2012/01/FINAL-Louisiana-Healthcare-Connections-Provider-Manual-FINAL-09-131.pdf?fbd2e4). Providers are taught that the manual contains exhaustive information about billing requirements and claims submission, described in detail above.
- Fax Blasts, which are used to communicate new or changed billing requirements

- Quick Reference Claims Requirements, such as our EDI Payer ID; acceptable claims forms for paper claim submission, and the mailing address for submitting paper claims; addresses for filing a corrected claim, reconsideration or appeal; and timely filing guidelines
- Forms to use and information to include when filing a claims appeal

### Ongoing Provider Education

LHCC recognizes the importance of keeping our providers up to date with changes in billing requirements and updates or enhancements in our processes, as well providing information about performance and recommendations for improvements in billing and claims

submission. Therefore, in addition to our initial provider training we offer a variety of other opportunities for providers to receive education, including education related to billing and claims submission.

**Provider Workshops.** Provider Workshops are large scale, regional provider education seminars where we discuss LHCC operations within that particular locale. The data presented only encompasses information, such as claim payment information, that we have in our system for the defined practices in that geographic area and we attempt to demonstrate how that area matches up against the entire network. During these workshops we review everything claims-related, such as quality metrics, claims payment, turnaround time, denial reasons, and health plan policy updates. The target audience for these workshops is all practice and billing managers, hospital account managers, and clinicians in the locale. Our goal is to have at least one provider workshop in each major metropolitan area during the course of the year. In 2014 we have conducted these workshops in the following service areas:

- New Orleans(January 2014)
- Shreveport(February 2014)
- Baton Rouge(June 2014)
- Lafayette(July 2014)
- Monroe (August 2014)
- Lake Charles(September 30, 2014)
- Alexandria(October 28, 2014)

General information included in provider workshops includes:

- GSA-specific Claims Payment Summaries (billed, allowed and paid amounts)
- GSA-specific Claim Adjudication Summaries, by provider type (hospital, specialist/primary care practices and ancillary) showing claims received, paid, pending and denied
- GSA-specific Claim Payment and Denial Rate Summaries, showing % of claims paid, pending and denied)
- GSA-specific Average Claim Adjudication Turnaround Times
- Health Benefit Ratio (HBR), including HBR by region, definition and DHH requirements for CCNs
- Provider Incentive Programs

In addition to this general information, LHCC also provides information about the top reasons that claims deny and offer suggestions for how to prevent these common claim denials. For example, to avoid a denial for a duplicate claim, when resubmitting a claim, the claim form must clearly indicate “corrected claim” and the original claim number.

As an example, in April of this year, we were a silver level sponsor for and participated in an event with the **Louisiana Medical Group Management Association (LMGMA) Greater New Orleans Chapter**. Approximately 40 medical managers attended in just one meeting. LHCC spoke for 45 minutes on the topic

*Since 2012, we conducted Provider Workshops in each GSA and each major metropolitan area in the state, along with over 3,000 individual provider meetings. Over 1,000 of these visits were related to new provider orientation visits which covered billing and claims submission in detail.*

of Payer Updates which included key topics such as our Claims Adjudication Statistics, Top 5 Claim Denials, Claims Payment Turn-Around-Times, and Health Plan Policy Updates.

**Individual Provider Training.** One of the best and most frequent opportunities for LHCC to provide billing and claims training occurs during our Provider Relations Specialists' office visits with our providers.

During these visits, providers and their staff can receive education that addresses their specific questions or concerns. As an existing Bayou Health CCN, we listen to our providers and make improvements to our education processes to address their concerns. For

example, when we initially began visiting providers and offering data and reports about billing and claims performance, we were providing information from a broader regional level. We listened to our providers and learned that what was most important to them was information about their own billing and claims payment performance. As a result, our External PR Specialists now come armed with 90 Day Provider Claims Reports that include information including a claims payment summary; a denial report that includes reasons for each denial; and a Turn Around Time report so that providers can see how quickly they bill and now long claims

**LHCC listened to our providers and developed a 90 Day Provider Claims Report that Provider Relations Specialists can use to provide targeted education to providers based on their own billing and claims submission practices.**

processing takes from the original date of service. These reports serve as a valuable tool for PR Specialists to tailor billing and claims education to meet the specific needs of the provider.



**Newsletters and Fax Blasts.** LHCC sends out quarterly Provider Newsletters as well as routine Fax Blasts for our Providers. These are archived on our open Provider Portal so that providers can access and retrieve the information at any time. In many instances, there is billing and claims education included on pertinent topics. LHCC uses Fax Blasts as a means to communicate changes in policies or processes that may impact claim submission or payment quickly to a large number of providers. Examples of Provider Fax Blasts that have contained education on a billing or claims issue include:

- Modifier 25
- ACA Reimbursement Q&A
- Claims Recoupments and Cross Over Codes
- FQHC-RHC Office Service Codes
- CLIA Implementation
- TDaP Coverage Information
- ICD-10 Readiness Assessment
- New provider Void Claim Request
- Rebilling Voided Claims
- Lab Testing for Drug Use and Genetic/Molecular Diagnostics

**Call Center.** Our call center Customer Service Representatives (CSRs) train and educate providers on billing requirements and other provider related topics. Through internal training and information readily available we are able to provide consistent information to providers. If additional training or support is needed, our CSRs route a request to our Internal/External PR Specialists to follow up according to the provider needs.

**Joint Operating Committees (JOCs).** Provider Relations staff participate in JOCs with large hospital systems, provider groups, and provider associations on a quarterly basis. These JOC meetings involve various departments from within LHCC such as, but not limited to, network and contracting, billing, and utilization management; and also include provider office or delegated vendor staff. During these meetings, we identify areas (for both organizations) for which operational improvements are needed or required, and where additional education and training may be necessary. The JOCs track any improvement activities determined to be necessary by the JOC, including training and education on billing and related areas. LHCC and our partners also discuss areas in which we can help to enhance their network participation experience, including related to administrative requirements and training.

“In addition to the educational support provided to the LPCA by LHC, I have the privilege to serve on Centene’s (LHC’s parent company) FQHC Advisory Committee that meets regularly to discuss FQHC operations, the managed care environment, and additional opportunities for collaboration.”

**Jonathan Chapman, Louisiana Primary Care Association, Inc., Executive Director**

**Provider Training Request.** Our Customer Service call center receives provider calls and if education is needed beyond the information provided, they send the information to an External PR Specialist for follow up. The PR specialist then determines whether the provider needs a full orientation, or a more specific training based on key topics, such as billing. Once determined, the External PR Specialist educates the provider depending on the request or need.

**Training Frequency.** In general, ongoing training is a continuous process that occurs during routine onsite provider visits. We also provide additional training based on provider requests, internal department requests for provider education, new plan or regulatory policies, processes or information related to billing or other provider requirements. We train new practice staff when previously trained staff change roles or decide to leave the practices. We also understand billing requirements change and practice staff need to be made aware of changes so they can receive accurate and timely claims payment. While we communicate with fax blasts and other bulletins, our External PR Specialists meet with providers on a regular basis (as outlined below) in effort to continuously educate and support providers and their staff regarding ongoing training needs such as billing requirement changes: The frequency with which our PR Specialists meet with providers is reflected in the table below:

**On-going Provider Visit Frequency**

Membership	Frequency
<1000	Monthly
500-1000 members	Bi-Monthly
100-499 members	Quarterly
> 100 members	Annually

### Examples of Process Improvements based on Experience and Provider Feedback

As an existing Bayou Health plan we have been able to develop strong relationships with our network providers. They give us candid feedback and we listen to that feedback and make changes in training, policy or processes related to billing or claims payment as a result. Some examples include:

- **Void Claim Request Form.** Previously there was no formal policy that would allow providers to request that the health plan void claims that previously paid. This resulted in inconsistencies in

what was being requested to complete this action which often resulted in incompleteness of the task. The Provider Void Claim Request Form made these requirements of this request more uniform and visible to providers on the proper procedure to complete this claim activity.

(<http://www.louisianahealthconnect.com/files/2014/04/ProviderClaimVoidForm-4-2-14-FINAL.pdf>).

- **Prior authorization Requirements for Ultrasounds.** LHCC's standing policy had been that a provider must get authorization after the second ultrasound performed within a 270 day period for a member. Through consistent feedback from the provider it was determined that there were many instances in which additional ultrasounds were being provided due to the urgent condition of the mother when presented, which resulted in claim denials for the provider performing the ultrasound because they didn't have the time obtain a prior authorization. As result of this provider feedback, LHCC changed its policy to remove the authorization requirements for ultrasounds to ensure that members would be able continue to receive this service when they present in an urgent condition.
- **90 Day Provider Claim Reporting.** As described above, during field visits we consistently heard feedback from providers requesting more information regarding their portfolio of business with LHCC instead of just providing a global picture of the issues occurring within the entire network that may not be impacting the unique provider. As result LHCC developed a provider specific claim report that would allow the PR Specialist to identify the claim payment history, top denials/rejections and claims adjudication TAT to educate the provider appropriately.

### Specialized Provider Service Staff to Ensure Accuracy of Training and Educational Materials

**Contract Implementation Analysts.** One of the most important roles within our Provider Relations Department is that of our Contract Implementation Analyst (CIA) staff. CIAs ensure we review and update requirements based on DHH recommendations, CMS, and NCQA standards related to claims billing and processing, consistent with industry norms, and comply with these recommendations within 90 calendar days from notice received by DHH, in accordance with Section 17.1.9. They also ensure that other provider-facing PR staff understand billing standards and requirements so they can provide the level of training and education our providers may need.

In addition, we proactively identify configuration changes needed during regular quality audits and weekly check run reviews to ensure accuracy and increase claims processing automation where possible. As a result of this effort, along with coordinating with our Claims Department, we maintain an average

Due to LHCC's provider training and outreach efforts, our EDI submission rate is consistently above 94% of overall claims received.

automatic adjudication rate of over 87% for claims submitted, meaning those claims systematically adjudicate according to DHH and federal requirements with no manual intervention. Our Claims Processors examine less than 13% of submitted claims (pending claims). LHCC has the highest rate of auto adjudicated

claims among all other Centene plans.

Our CIA staff ensure all updates and changes to Medicaid billing and processing requirements (including, but not limited to, fee schedule rates, policies and codes) being communicated to providers by PR Specialists through training and other educational approaches are reviewed and configured in the Provider Relationship Management (PRM), which is then updated in AmisysAdvance, (our medical and behavioral health claims processing system) in a timely and accurate manner.

**External Provider Relations Specialists.** Strategically located throughout the state in Shreveport, Lafayette, Baton Rouge, and New Orleans, our External PR Specialists live and work in their locally assigned geographies. They have established strong relationships with our providers and their *primary*

*focus is provider education related to billing and claim submission accuracy*, our Provider Portal, and problem resolution.

Our staff utilize a Provider Visit Record (PVR) to proactively prepare for each provider visit by pulling together provider reports and information such as, but not limited to, customized claims activity metrics, top claim denial trends, information on new health plan policies, member care gap reports, and HEDIS performance reports. Reflective of our dedication to Louisiana providers, our External PR Specialists spend on average a full hour with providers during an onsite visit. We require each PR rep to make at least 40 unique provider/facility visits each month and they also coordinate and attend Joint Operating Committee meetings with hospitals, large physician groups, and provider associations, such as the Louisiana Primary Care Association, on a quarterly basis.

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**Effective February 1, 2015 we will have  
a total of 11 External PR Specialists  
strategically located in each of the 9  
regions throughout Louisiana**

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**Internal Provider Relations Specialists.** We invested in our providers by employing local, highly experienced Certified Professional Coders (CPC) as Internal PR Specialists. Our local, specialized unit allows us to expedite the research, accuracy and response time on provider claims issues. Our coders speak the same language as the facility and professional office billers and allows them to offer a level of technical training that wouldn't otherwise be available. They know medical terminology, coding, and claims as well as industry standard coding practices. If through their research they determine the denied claims result from provider billing errors, they work onsite with the External PR Specialists and the provider billing staff to discuss solutions directly.

**Claims Liaisons.** Our Claims Liaisons coordinate with our Internal and External PR staff to ensure providers are educated related to any billing requirement changes or trained related to guidance needed to improve claims processing. They are available to support PR Specialists with targeted education and training as needed.

**Internal Training.** LHCC PR trains internal departments and staff related to new or changed billing information and updates. We use provider resources (e.g. forms, tools, newsletters, letters, fax blasts, website posts, etc.) across our organization to ensure we impart consistent information to providers. PR meets with each department either on a weekly or biweekly basis to ensure updated communications are shared, as well as, to take a proactive approach to issue resolution, process improvements, or systems configuration changes needed. We update provider tools such as fax blasts and Provider Newsletters based on the internal meetings and distribute to affected providers. Although other Plans tend to be reactive when an issue occurs, we identify, review, and resolve issues before they become a larger problem.

### Tracking Provider Training

PRM, LHCC's Provider Relationship Management system (discussed below) tracks all communication with providers for education and training by either Provider Relations Specialists or our call center. Providers and attending staff sign PVRs and sign-in sheets, which we use to confirm who attended the training. The information from the PVR is entered into PRM for tracking purposes.

We log all provider contact, visit, and training activity into PRM to help streamline inter-departmental communications. By documenting all calls to/from providers and the core

### LHCC in Action...

**During one of our recent provider training sessions, a provider shared feedback in the survey stating**

*"It was appreciated the amount of time that was spent with myself and staff to explain things to us."*

departments in one place, we see previous calls and education provided, which improves communication between providers and internal departments.

Simultaneously, the PVR data is also loaded into our SharePoint site to allow our data analyst within PR to pull reports quickly identifying the various provider practice data captured at the time of the visit or training delivered (such as the type of training performed, whether individual practice or group sessions, as well as the training topics covered). This information is tracked, trended and reported to leadership and to QI, at minimum, on a monthly basis.

**Training Manual.** LHCC will comply with Section 10.5.2. by submitting a copy of the Provider Training Manual and training schedule to DHH for approval within 30 calendar days of the date we sign the Contract with DHH, if awarded. Any changes to the manual will be submitted to DHH at least 30 calendar days prior to the scheduled change and dissemination of such change.

### Evaluating Provider Training

**Overview.** LHCC welcomes feedback on the effectiveness of our Provider Training Program and training sessions, particularly on how we can improve the provider's and/or office staff experience. As described above, our External PR Specialists document all information discussed and provided during their routine provider visits in the PVR. This includes, but is not limited to, confirming receipt of the information shared with the provider by our staff and validating provider demographic and billing information. Provider staff review, provide comments, and sign the PVR at the end of each visit to ensure both parties agree on the information provided.

In addition, Providers complete a survey at the time of the orientation or routine follow-up visits. We also send a survey to providers 90 days after they receive a new provider orientation, which gives them an opportunity to raise any additional feedback (positive or negative) since the initial orientation for LHCC to address. We review and evaluate survey results for any follow up or improvements.

LHCC PR leadership evaluate the provider service and education provided based on visit metrics from PVRs, completed orientation surveys, and periodic quality checks by randomly following up with providers and pop-up visits where leadership attends a scheduled meeting with an External PR Specialist.

**Results.** In June 2014, the Provider Relations Department implemented a process to assess provider satisfaction with routine follow-up visits to assess if time spent with the provider met their expectations on items varying from providing updates on previously communicated inquiries and health plan policy updates, to changes on the provider's roster.

The survey consists of 9 questions to rate the PR specialist on the following rating scale:

- Well Below Average: 20 points
- Below Average: 40 points
- Average: 60 points

"One of the challenges of the initial Bayou Health implementation was the loading of correct provider information into LHC's claim system to reduce unnecessary delays in claim processing and administration. LHC worked diligently with us to ensure providers were loaded timely and accurately. While there is no doubt that patient care is the most important consideration, efficient administration is important to the success of a program and LHC's diligence in this capacity significantly reduced potential administrative issues at start up. We continue to work with them to further streamline administrative process around provider data and implementation."

**Joseph A. Bonsignore, President, Acadian Healthcare Alliance**

- Above Average: 80 Points
- Well Above Average: 100 points

On average, since we fully implemented the PVR process, our provider survey results demonstrated “above average” and “well above average” satisfaction from our related to provider education and training. While we continuously review provider feedback to identify any areas of improvement and trends, in general, our providers are satisfied and report no issues.